DOCUMENT RESUME

ED 177 834 RC 121 603

AUTHOR	Gelles, Richard J.
TITLE	Final Report on Defining and Classifying Cases of Child Abuse in Rhode Island.
INSTITUTION	Rhode Island Univ., Kingston.
SPONS AGENCY	National Center on Child Abuse and Neglect (DHEW/OHD), Washington, D.C.
PUB DATE	[Sep 79]
GRANT	90-C-425
NOTE	124p.
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	*Child Abuse; Counselors; *Definitions; Elementary Education; *Identification; Labeling (of Persons); Physicians; Police; Principals; *Professional Personnel; Social Workers; *State Surveys
IDENTIFIERS	*Rhode Island

ABSTRACT

A questionnaire survey of 565 professionals in seven occupational and organizational contexts (physicians, psychiatrists, elementary school counselors and principals, public and private social workers, and police officers) in Rhode Island was undertaken to investigate the process by which child abuse is defined and identified. In addition to the structured questionnaire, informal, unstructured interviews were conducted with 79 professionals who had reported at least one case of child abuse in 1975. Findings indicated that: (1) there is not one, uniform accepted (or acceptable) definition of child abuse used by a majority of professionals who encounter cases of child abuse; (2) definitions of abuse vary among professional groups; (3) the process by which cases are identified and labeled "child abuse" varies, and varies by professional group; and (4) the definitions of abuse and labeling processes employed by professional groups mean that two types of errors in case diagnosis are going to be made--some cases of child abuse will be incorrectly diagnosed as "not abuse," while cases which are not abuse will be incorrectly labeled "child abuse." Tables with statistical data and a copy of the survey instrument are included. (Author/SEH)

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FINAL REPORT ON DEFINING AND CLASSIFYING CASES OF CHILD ABUSE IN RHODE ISLAND

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Final Report Submitted to:

NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

Children's Bureau/Administration on Children Youth and Families

Office of Human Development Services/Department of Health, Education and Welfare

Research Supported by Grant Number 90-C425

Principal Investigator: Richard J. Gelles

EC121603

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INTRODUCTION

The basic tenet and central goal of all social science is to understand, explain, and predict human behavior. The goal becomes even more meaningful and more important when one focuses on a topic area which has been identified as a major social problem. Understanding, explaining, and predicting child abuse is more than a social scientific academic exercise--it has implications for the protection of the very lives and well being of children who are abused or who are at risk of being abused. Pictures of abused babies, gruesome stories of the unbelievable measures some parents take to abuse children, publicity campaigns, and political efforts on state and national levels all galvanize attention on preventing child abuse. In order to prevent abuse, we must be able to predict the occurrence of child abuse, and if we are to adequately predict a phenomenon, we must certainly be able to explain it.

Our research on the process by which child abuse is defined and identified by professionals has foresaken the traditional research tact of undertaking a study aimed at explaining child abuse. It was our belief when we proposed our research, and we are even more convinced now, that there is no objective phenomenon which can be defined as "child abuse" (Gelles, 1975). Child abuse cases, as we have previously argued, are products of social labeling and social processes by which behavior of caretakers is labeled as abusive or states of their children are recognized as being abuse. Once the label "abuse" has been attached, the labeler must be able to make the label "stick". Thus, what is perceived as being child abuse will vary from individual to individual and professional group to professional group; and, the processes used to affix the label "child abuse" means that certain children and families are tagged as abused and abusers while others are insulated from the label--despite engaging in the same behavior as those who have been

labeled child abusers.

Our research to date indicates that: 1) there is not one, uniform accepted (or acceptable) definition of child abuse used by a majority of professionals who encounter cases of child abuse; 2) definitions of "abuse" vary among professional groups; 3) the process by which cases are identified and labeled "child abuse" varies, and varies by professional group; and, 4) the definitions of abuse and labeling processes employed by professional groups mean that two types of errors in case diagnosis are going to be made--some cases of child abuse will be incorrectly diagnosed as "not abuse", while cases which are not abuse will be incorrectly labeled "child abuse".[1]

METHOD

The Sample

In January, 1976 we used a mailed questionnaire to survey professionals in seven occupational and organizational contexts. Questionnaires were mailed to 313 physicians in Rhode Island--a population sample of general practitioners, family practitioners, pediatricians, psychiatrists, and four other specialities who deal with children and families. Sixty-eight questionnaires were mailed to elementary school guidance counselors (a population survey). A 50 percent random sample of elementary school principals in the state received questionnaires (147). Seventeen Emergency Room physicians (a population sample) also received questionnaires. Questionnaires were mailed to officials in all private social service agencies in the state and 96 clinicians returned completed questionnaires (out of 196 mailed). The state department of Social and Rehabilitative Services distributed questionnaires to all 120 child and family workers employed by the state. Lastly, an accidental sample of 106 police officers completed questionnaires.

The response rate for the entire mailing was 53 percent (See Table 1). The highest response rate was for principals (74 percent), the lowest was public social workers (41 percent).

In addition to the structured questionnaire we conducted informal, unstructured interviews with 79 professionals who had reported at least one case of child abuse in 1975. These interviews added qualitative data to the quantitative data available from the mailed survey.

TABLE 1

Child Abuse in Rhode Island: Response Rate

OCCUPATIONAL GROUP	PHYSICIANS		COUNSELORS		PRINCIPALS		PRIVATE SW		PUBLIC SW		POLICE		ER MD		TOTAL
ADJUSTED SAMPLE SIZE*	313		68		147		193		120		106		19		966
SAMPLING TECHNIQUE	direct mail		direct mail		direct mail		mailed to & dist. by supervisors		mailed to & dist. by supervisors		classroom distribution		direct mail		
NUMBER RETURNED BY END OF WEEK	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
1	59	19 #	7	10 #	29	20 #	17	9	31	26	6	na	2#	11	
2	80	26	17	25	55	37	44	23	42	35	61	na	2	11	
3	95	30 #	33	48 #	77	52 #	57	29	47	39	67	na	4#	21	
4	111	35	36	53	93	63	67	34 #	47	39 #	106	na	5	26	
5	124	40	41	60	98	66	72	37	48	40	106	na	5	26	
6	128	41	41	60	98	66	75	39	48	40	106	na	5	26	
7	129	41 #	42	62 #	100	68 #	80	41	49	41	106	na	6#	32	
8	140	45	44	65	105	71	85	44	49	41	106	na	6	32	
9	148	47	45	66	107	73	89	46	49	41	106	na	6	32	
10+	150	48	48	71	109	74	93	48	49	41	106	na	7	37	
TOTAL	150	48%	48	71%	109	74%	93	48%	49	41%	106	na	7	37%	565 58%

*Less deaths, retirements, job change, moved out of state, or undeliverable mail

#Followup postcard or letter mailed

DEFINING CHILD ABUSE

Subjects were asked to indicate whether they viewed a particular condition as child abuse. A list of thirteen items was presented and subjects were asked whether they felt the condition was child abuse, was not child abuse, or whether they were not sure.

Child Abuse

There was strong agreement among the seven professional groups surveyed that four conditions were child abuse. Ninety-eight percent (98%) of the professionals viewed willful malnutrition as abuse, ninety-six percent (96%) defined sexual abuse as child abuse, ninety-five percent (95%) stated that willfully inflicted trauma was abusive, and eighty-two percent (82%) of the respondents considered locking a child in a dark closet child abuse.

The commonality of the conditions defined as child abuse by more than eighty percent of the professionals was that the conditions involved acts where there presumably was a direct intent to injure or harm the child (willful malnutrition, willfully inflicted trauma). In addition, three of the conditions involved some injury or harm to the child (malnutrition trauma, abuse) while the fourth indicated no injurious or harmful outcome (being locked in a dark closet).

Definitions by professional group. More than eighty percent of all professionals surveyed defined willful malnutrition, willfully inflicted trauma, and sexual abuse as child abuse. Only in the case of physicians did less than eighty percent of a professional group not define locking a child in a dark closet as abusive.

Variations in defining conditions as abuse. While there appeared to be a fairly high level of consensus among the professionals as to what abuse was, there were some interesting variations between professionals. Elementary school principals were much more likely to view injury to a child arising out of carelessness of the parents as being child abuse. Police officers were more likely than other occupational groups to define poor housing conditions as child abuse. Principals also defined this condition as child abuse.

A consensus of opinions was found when defining sexual abuse, willful malnutrition, and willfully inflicted trauma as child abuse. There was less than a ten percent difference between all seven groups on these items. The greatest variation in defining a condition as abuse occurred for the conditions of a child being injured when struck too hard by the parents. Here the variation was over fifty percent. There is a strong indication that the reason the seven groups varied so greatly on this item was while an injury occurred, there was a lack of clear intent to cause injury. Moreover, punishing a child through physical force is often considered normatively acceptable and this may mitigate against an injury resulting from this being viewed as abuse.

What is Not Child Abuse

Unlike the case of defining a condition as child abuse, there was no clear consensus as to what conditions were not child abuse. Seventy percent (70%) of the professionals surveyed defined malnutrition due to poor family finances as "not child abuse." Sixty four percent (64%) did not consider poor health services available for the child as abuse; while sixty percent (60%) of the professionals indicated that child abuse was not an injury

due to poor housing conditions.

What is not child abuse seems to hinge on whether the injury or damage done to the child was a result of factors beyond the normal control of the parents. Clearly there is injury in malnutrition and physical damage caused by poor housing, but the professionals surveyed appeared to view this damage as a product of social conditions, not personal or family ones. Thus, child abuse is defined only as injuries or harm caused to a child by something a parent or caretaker has control over.

Definitions by Professional Group. Only malnutrition caused by poor finances was defined as "not child abuse" by more than sixty percent of each professional group. Physicians defined five conditions as not being abuse: poor health services available, injury caused by poor housing conditions, malnutrition due to poor finances, malnutrition due to ignorance, and overfeeding. Public social workers and emergency room physicians viewed three conditions as "not abuse": malnutrition due to ignorance and finances and poor health services available. Private social workers restricted their definitions of "not abuse" to poor health services available and malnutrition due to poor finances. Elementary school counselors, principals, and police officers selected one condition, malnutrition due to poor finances as not child abuse.

Variations in defining conditions as "Not Child Abuse". When professionals defined what was child abuse the greatest amount of consensus occurred when they viewed conditions as abuse; thus, the least variation in the "not abuse" responses occurred for willful malnutrition, willfully inflicted trauma, and sexual abuse. Very few professionals said these acts were "not abuse", and the variation was minimal between professional groups. Of the acts defined as "not abuse" the least variation occurred for malnutrition

due to poor finances. The greatest variation in the "not abuse" responses was for injury caused by inadequate precautions taken by the caretaker, injury caused by poor housing conditions, and malnutrition due to parental ignorance. Nearly thirty percentage points differentiated the professional group most likely to see these acts as "not abuse" from those least likely to see these acts as "not abuse".

Emergency room physicians were quite unlikely to define injury due to inadequate precautions taken by the caretaker as "not abuse". Either these professionals react mainly to the injury to the child, or they are less likely to believe the parents' accounts of how the injury occurred (or both). Physicians were considerably more likely to view injuries arising from poor housing conditions as "not child abuse".

Undecided

The professionals surveyed were given a third choice when they had to decide whether a condition was child abuse or not--they could choose to say that they were undecided. The condition which elicited the most undecided selections was a child being injured due to inadequate precautions taken by the parent or caretaker. Twenty-eight percent (28%) of the professionals could not decide if this was abusive or not. Twenty-two percent (22%) of the professionals were undecided about lack of emotional and intellectual stimulation, twenty-one percent (21%) were undecided about a child being injured due to poor housing conditions, and twenty percent (20%) were undecided about an injury arising out of parental carelessness.

Injury caused to a child as a result of poor precautions taken by a caretaker produced an almost even split among professions with thirty-five percent (35%) viewing this condition as abuse, thirty-four percent (34%) identifying it as "not abuse", while twenty-eight percent (28%) of the

professionals who deal with child abuse were undecided. In the case of lack of emotional and intellectual stimulation, thirty-seven percent (37%) of the respondents said this was abuse, nineteen percent (19%) viewed it as non abusive, while twenty-one percent (21%) were undecided.

There appears to be no specific trend which led professionals to view conditions as neither "abuse" or "not abuse". The ambiguity seemed to be most prevalent in conditions where the nature of the injury was ambiguous (overfeeding, lack of emotional or intellectual stimulation), or where the injury was caused by circumstances where intent was difficult to establish or pinpoint. Interestingly, the greatest ambiguity arose over an injury due to inadequate precautions taken by a parent. Here there is a defined injury, but the parent's role was neither active intent nor was the injury totally out of the hands of the parent. If the parent should have known better but did not act on that, and the child is injured, professionals have a difficult time deciding whether this constitutes abuse.

What is Child Abuse

In summarizing the definitions of child abuse held by various professional groups we must point out that any inferences which we can make from these definitions to actual behavior are at best tentative. There can be a considerable gap between how a professional defines child abuse when responding to a questionnaire and how the same professional acts when faced with a child and family where the possibility of abuse exists. The best conclusions which we can draw are that the definitions which professionals hold of child abuse serve as cognitive lenses which guide them in their interaction with children and families. The definition serves as a screening mechanism--those acts defined as abuse will be more likely to be located and identi-

fied as abuse, those acts clearly defined as not being child abuse will be screened out, while the other conditions will cause some thought and whether these conditions are found to be abuse may depend on factors beyond the simple characteristics of the condition itself.

We are able to deduce that major characteristics are common to conditions defined as abuse. First, there must be some clear, identifiable harm or injury to the child and second, there must be evidence of clear intent on the part of the parent to produce this injury or harm. When such intent is absent, there typically is some doubt as to whether the condition is abuse.

Conditions which are defined as not being abuse are those where there is a lack of clear intent to injure or harm the child. Numerous conditions which were defined as injurious to the child were defined as "not abuse" because the cause of the injury was stated as something beyond the immediate control of the caretaker. This indicates that the conventional definition of child abuse employed by professionals is much more attuned to intent than the actual state of the child.

Ambiguity arises when neither intent nor the nature of the injury can be determined. Despite the fact that state law defines mental injury as child abuse, a large number of professionals are not willing to define conditions of "mental abuse" as child abuse because there is no clearly identifiable harm.

We found some clear variations of definition by professional groups. Medical personnel were much more likely to define acts where physical injury took place as abusive. Professionals who interact with children in settings which involve the total child (physical and emotional) were more likely than physicians to define conditions where the injury was not

purely physical as child abuse.

A striking facet of the question of definitions of child abuse is the lack of a clear consensus on any condition being child abuse. Even in the case of a condition defined as abuse (sexual abuse) there was complete agreement that this was abuse by only one professional group--emergency room physicians. Thus, it is apparent that even when there is a clear injury and clear intent, some members of some professional groups are not going to view the act as child abuse. Moreover, there are numerous conditions such as a child being injured as a result of inadequate precautions taken by the caretaker where equal numbers of professionals view the condition as abuse, non abuse, or they are undecided.

TABLE 2

PERCENT DEFINING

Willfully Inflicted Trauma

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=148)	5.4	94.6	0
Counselors (N=48)	2.1	97.9	0
Principals (N=107)	2.8	96.3	.9
Private Social Workers (N=96)	0	99	1
Public Social Workers (N=49)	2	98	0
Emergency Room Physicians (N=9)	0	100	0
Police Officers (N=103)	6.8	87.4	5.8
Total (N=560)	3.6	95	1.4

TABLE 3

PERCENT DEFINING

Injured Due to Carelessness

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=148)	22.3	50.7	27
Counselors (N=48)	12.5	72.9	14.6
Principals (N=108)	22.2	53.7	24.1
Private Social Workers (N=95)	28.4	55.8	15.8
Public Social Workers (N=49)	20.4	44.9	34.7
Emergency Room Physicians (N= 8)	25	50	25
Police Officers (N= 105)	11.4	63.8	24.8
Total (N= 561)	20.3	56	23.7

TABLE 4

PERCENT DEFINING

Willful Malnutrition

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=148)	2	97.3	.7
Counselors (N=48)	0	97.9	2.1
Principals (N= 109)	1.8	98.2	0
Private Social Workers (N= 96)	0	100	0
Public Social Workers (N=49)	0	100	0
Emergency Room Physicians (N= 9)	0	100	0
Police Officers (N=106)	.9	95.3	3.8
Total (N=565)	1.1	97.9	1.1

TABLE 5

PERCENT DEFINING

Lack of Emotional and Intellectual Stimulation

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=147)	27.2	34	38.8
Counselors (N=47)	19.1	44.7	36.2
Principals (N= 108)	30.6	25.9	43.5
Private Social Workers (N=96)	16.7	40.6	42.7
Public Social Workers (N=49)	12.2	49	38.8
Emergency Room Physicians (N= 9)	11.1	44.4	44.4
Police Officers (N=106)	15.1	42.5	42.5
Total (N=562)	21.5	37.5	40.9

TABLE 6

PERCENT DEFINING

Malnutrition Due to Ignorance

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=148)	18.9	16.2	64.9
Counselors (N=48)	22.9	27.1	50
Principals (N=109)	19.3	19.3	61.5
Private Social Workers (N=95)	18.9	23.2	57.9
Public Social Workers (N=49)	20.4	12.2	67.3
Emergency Room Physicians (N= 9)	11.1	11.1	77.8
Police Officers (N= 105)	13.3	38.1	48.6
Total (N=563)	18 3	22.6	59.1

TABLE 7

PERCENT DEFINING

Malnutrition Due to Finances

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=148)	16.9	14.2	68.9
Counselors (N=48)	8.3	14.6	77.1
Principals (N=109)	20.2	5.5	74.3
Private Social Workers (N=95)	20	14.7	65.3
Public Social Workers (N=49)	14.3	16.3	69.4
Emergency Room Physicians (N=9)	11.1	11.1	77.8
Police Officers (N=106)	8.5	22.6	68.9
Total (N=564)	15.4	14.4	70.2

TABLE 8

PERCENT DEFINING

Overfeeding

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=147)	18.4	17.7	63.9
Counselors (N=48)	22.9	31.3	45.8
Principals (N=109)	26.6	22	51.4
Private Social Workers (N=95)	18.9	34.7	46.3
Public Social Workers (N=49)	26.5	30.6	42.9
Emergency Room Physicians (N=9)	33.3	11.1	55.6
Police Officers (N=105)	20	27.6	52.4
Total (N=562)	21.7	25.4	52.8

TABLE 9

PERCENT DEFINING

Injured When Struck too Hard

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=148)	18.9	62.2	18.9
Counselors (N=47)	23.4	72.3	4.3
Principals (N=108)	13	75	12
Private Social Workers (N=96)	17.7	75	7.3
Public Social Workers (N=49)	18.4	75.5	6.1
Emergency Room Physicians (N=9)	33.3	44.4	22.2
Police Officers (N=105)	10.5	62.9	26.7
Total (N=562)	16.5	68.7	14.8

TABLE 10

PERCENT DEFINING

Poor Health Services Available

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=146)	13	13	74
Counselors (N=48)	27.1	16.7	56.3
Principals (N= 107)	27.1	15	57.9
Private Social Workers (N= 94)	16	21.3	62.8
Public Social Workers (N= 48)	16.7	10.4	72.9
Emergency Room Physicians (N= 9)	11.1	11.1	77.8
Police Officers (N= 106)	11.3	33	55.7
Total (N=558)	17.4	18.6	64

TABLE 11

PERCENT DEFINING

Injured Due to Poor Housing

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=148)	14.9	10.8	74.3
Counselors (N=47)	23.4	29.8	46.8
Principals (N= 108)	26.9	14.8	58.3
Private Social Workers (N=93)	22.6	21.5	55.9
Public Social Workers (N= 48)	29.2	14.6	56.3
Emergency Room Physicians (N= 9)	33.3	11.1	55.6
Police Officers (N= 105)	18.1	26.7	55.2
Total (N=558)	21.3	18.3	60.4

TABLE 12

PERCENT DEFINING

Sexual Abuse

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=148)	3.4	91.9	4.7
Counselors (N=48)	2.1	95.8	2.1
Principals (N=109)	.9	99.1	0
Private Social Workers (N=96)	1	99	0
Public Social Workers (N=49)	2	98	0
Emergency Room Physicians (N=9)	0	100	0
Police Officers (N=104)	1.9	96.2	1.9
Total (N=563)	2	96.3	1.8

TABLE 13

PERCENT DEFINING

Lock in Dark Closet

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=148)	16.2	73	10.8
Counselors (N=48)	6.3	85.4	8.3
Principals (N=109)	17.4	80.7	1.8
Private Social Workers (N=96)	10.4	87.5	2.1
Public Social Workers (N=49)	14.3	85.7	0
Emergency Room Physicians (N=9)	0	100	0
Police Officers (N=106)	5.7	85.8	8.5
Total (N=565)	12.2	81.9	5.8

TABLE 14

PERCENT DEFINING

Child Injured Due to Inadequate Precautions Taken by Parents

AS CHILD ABUSE BY OCCUPATION

Occupation	Undecided	Yes	No
Physicians (N=143)	29.4	30.1	40.6
Counselors (N=47)	31.9	40.4	27.7
Principals (N=106)	32.1	35.8	32.1
Private Social Workers (N=95)	30.5	42.1	27.4
Public Social Workers (N=49)	24.5	36.7	38.8
Emergency Room Physicians (N=9)	33.3	55.6	11.1
Police Officers (N=105)	21	42.9	36.2
Total (N=554)	28.3	37.5	34.1

CAUSES OF CHILD ABUSE

We were interested in what factors professionals viewed as the causes of child abuse. We presented the professionals with a list of fourteen items which could be viewed as causes of child abuse. Each respondent was asked to rate each item in terms of how strongly the item was causally related to child abuse (0=Unrelated; 1=Weakly related; 2=Somewhat related; 3=Strongly related). In order to determine which factors were considered the most important and least important causes of child abuse we averaged the responses for each item. Thus, the higher the average score, the stronger the imputed relationship between the item and child abuse. The closer the average was to zero, the more unimportant the factor was as a cause of child abuse.

Causes: "Kinds of People"

Examining the entire sample of professionals, we find that child abuse is generally viewed as a problem caused by particular people with certain personal or personality problems. The respondents as a whole felt that "personality disorders" was the most important cause of child abuse (2.69). "Drinking" was considered the second strongest causal factor (2.64). The factor ranked third was the "maturity of the parents" (2.46).

Thus, the three items listed as the most strongly related causal factors were items which dealt with intra-individual problems of individual caretakers. It is clear that the professionals viewed child abuse as caused by individual pathologies or problems.

Less important factors included whether the "child was wanted by the parents" (2.39), whether the "parent was abused as a child" (2.34), and "drug usage" (2.29). It is not until the seventh most important item that

a social-situational factor, "stress on the family" (2.26), is considered as a cause of child abuse. Other social-structural conditions such as "family finances" (1.50), "father's unemployment" (1.47), and "isolation" (1.52) are considered to be more weakly related to child abuse than personality or other individual factors.

The factors which were considered largely unrelated by most professionals are "single parent family" (1.23) and "social class" (1.07).

Physicians

Physicians who were surveyed tend to view child abuse to be caused by personality problems of individual caretakers. The item rated as the most strongly related as a cause of child abuse was "personality disorders." "Drinking" and "maturity of the caretaker" were rated as the next most important causes. Physicians viewed "social class" and "single parent family" as only weakly related factors.

The physicians' selection of personality and other intra-individual factors as variables strongly related to child abuse, and their rating of social factors as being only weakly related is consistent with the medical profession's approach to this issue as revealed in published articles on child abuse by medical practitioners. Physicians, as a result of their training, tend to approach child abuse with a medical model of causation--viewing child abuse as caused by some pathology within the individual caretaker. The existence of the medical model approach is reflected in our research by the findings that physicians chose intra-individual factors and kind-of-person items as the most significant causes of child abuse.

Emergency Room Physicians

Physicians employed on a full time basis in emergency rooms of public

and private hospitals had a view of the causes of child abuse which was quite different from their colleagues in the medical profession who were in private practice or were full-time staff members of hospitals. The Emergency Room physicians saw "unwanted children" as being the most strongly related cause of child abuse. "Personality disorders", "drinking", and "caretaker maturity" were rated lower as causal factors by Emergency Room doctors than by their colleagues who practiced less crisis-oriented medicine. Another interesting difference was that physicians as a group saw the "child's behavior" as a stronger correlate with abuse than did Emergency Room physicians (Physician's mean=1.79; Emergency Room physician's mean=1.33). Other interesting differences were that social psychological variables such as "social class" and "single parent family" were rated slightly more important causal factors by Emergency Room physicians than by physicians in general.

Given that Emergency Room and other physicians tend to have similar backgrounds in terms of training and the socialization into the medical model paradigm, how is it that they differ in their view of the causes of child abuse? Although we have not yet examined specific cross-tabulations of data in order to explain these differences, we hypothesize that the differences are due to differences in terms of experience with cases of child abuse and the actual encounters the physicians have with abused children and their families. Emergency Room physicians may well have had much more contact with abused children. This contact might have afforded them more insight into the social-psychological dynamics of the families of abused children than their colleagues in general practice. For example, an Emergency Room physician's experience with abused children might have provided him or her with insights into whether the child was "wanted" by viewing the behavior of the parents in the emergency room. Similarly, the fact that an Emergency Room physician actually sees the consequences of abuse, might lead him or

her to conclude that the child could not have provoked such an assault (thus, the lower rating of "child's behavior" by the Emergency Room doctors).

In summary, the context of the experience with actual child abuse cases and the number of cases actually seen may have produced the different evaluations of the causes of abuse as viewed by members of the same profession.

Elementary School Counselors

Elementary school guidance counselors rated "personality disorders" as the strongest causal link with child abuse and their mean rating of this item (2.88) was higher than the mean of any other professional group.

Although counselors viewed personality problems as the most important cause of child abuse, they displayed sensitivity to social and environmental factors. The factor ranked second as a cause of child abuse was "parent abused as child." "Stress" was viewed as a more important causal factor by counselors than by physicians, Emergency Room physicians, or principals. At the other end of the continuum, "social class" was considered almost totally unrelated to child abuse (mean=.79).

It is interesting that counselors, one of the professional groups with the least contact with abusive parents, would rank "parent abused as a child" as such an important factor. Given that counselors have such limited contact with abusive parents, we might postulate that their attitudes towards the "vicious cycle of child abuse" is a result of their reading of the literature on this topic or a consequence of their professional training which may include contact with social learning theory.

Principals

Principals displayed one of the more striking variations in their analysis of the causes of child abuse. Principals rated "drinking" as the

prime cause of abuse. They also rated "drugs" as a more significant causal variable than did any other professional group. The other factors identified as important causal factors indicated that principals tended to see the root causes of child abuse as stemming from intra-individual pathologies or weaknesses.

Why principals were prone to view abuse as a result of alcohol or drug problems is interesting. There would appear to be nothing in their training or experience which would produce a view of child abuse as being caused by a chemical which causes a parent to loose control. Since principals are a professional group which probably encounters child abuse rarely if at all, and since the educational and occupational training principals receive typically does not include any information on child abuse, the choice of "drugs" and "alcohol" as causal factors may reflect the fact that principals employ a "common sense" view of child abuse which includes in it the assumption that abuse is caused by a parent or caretaker "loosing" control.

Social Workers: Public and Private

Social workers employed in public and private agencies shared the same causal paradigm of child abuse which evidenced a high degree of sensitivity to both social and psychological causes. Social workers listed "parent abused as child" as the strongest correlate with child abuse. "Personality disorders" was ranked second, while the third most important item was "stress." Social workers were the only professional groups which ranked "stress" as one of the three most important causes of child abuse.

"Social class" and "isolation" were rated last by social workers, but even in this ranking, the mean importance imputed to these items was higher for social workers than for other professional groups.

The consideration of both social and psychological factors as important causes of child abuse would appear to be a reflection of the model of causation taught to social workers and employed in their work. Unlike the medical model employed by physicians or the common sense model employed by principals, the social work paradigm includes an awareness and sensitivity to causes which exert pressures on people as well as forces which arise within the individual.

Police Officers

Police officers, like Emergency Room physicians, tend to encounter cases of child abuse in the crisis stage. This experience may well color their causal assessment of child abuse and explain why Emergency Room physicians and police officers had similar views of the causes of abuse.

Police rated "drinking" as the factor most strongly related to child abuse. The second strongest relationship was thought to be between "unwanted children" and abuse. "Personality disorders" and "drugs" were listed as the next most important causes.

We would hypothesize that "drinking" and "drugs" were rated as important causal factors because police tend to employ the common sense perspective which argues for elements that cause people to loose control as being important causes of child abuse. In addition, police, who are called upon to intervene in family disputes, tend to build a normal picture of family disputes and violence as arising out of drinking and drug problems.

Summary

Until we analyze the data more closely, we can only speculate as to what produces the varying perspectives used by professional groups in defining the causes of child abuse. There is a rather clear indication that

in most cases, the causal patterns identified by professionals are quite different than the causal patterns of child abuse discussed in the scientific literature. Thus, we can tentatively hypothesize that for our population, their view of the causes of child abuse was not developed from their reading of the literature; or, if they read the literature, they did not fully believe it. It appears that the causal "models" of child abuse held by most professional groups is a consequence of their professional training and the extent of and nature of their contact with abused children and abusive caretakers.

TABLE 15

Professional Ratings of Causes

of Child Abuse

(Mean Scores)

Factor	Mean*
Personality Disorder	2.69
Drinking (alcohol)	2.64
Maturity of Parents	2.46
Unwanted Child	2.39
Parent(s) Abused as Child	2.34
Drugs	2.29
Stress on Family	2.26
Child's Behavior	1.88
Parent's Expectations for the Child	1.69
Isolation	1.52
Family Financial Status	1.50
Unemployment of Father	1.47
Single Parent Family	1.23
Social Class of Family	1.07

* 3=Strongly related
0=Unrelated

TABLE 16

Physician Ratings of Causes of Child Abuse (Mean Scores)

Factor	Mean*
Personality Disorder	2.78
Drinking (alcohol)	2.62
Maturity of Parents	2.52
Unwanted Child	2.30
Drugs	2.15
Parent(s) Abused as Child	2.11
Stress	2.04
Child's Behavior	1.79
Parent's Expectations for the Child	1.49
Family Financial Status	1.48
Isolation	1.44
Unemployment of Father	1.40
Social Class of Family	1.27
Single Parent Family	1.20

* 3=Strongly related
0=Unrelated

TABLE 17

Emergency Room Physician Rating of Causes of Child Abuse

(Mean Scores)

Factor	Mean*
Unwanted Child	2.56
Drinking (alcohol)	2.44
Personality Disorder	2.44
Maturity of Parents	2.33
Stress	2.00
Drugs	1.67
Family Financial Status	1.67
Parent(s) Abused as Child	1.56
Parent's Expectations for the Child	1.44
Unemployment of Father	1.44
Single Parent Family	1.44
Isolation	1.44
Social Class of Family	1.44
Child's Behavior	1.33

* 3=Strongly related
0=Unrelated

TABLE 18

Elementary School Guidance Counselor

Ratings of Causes of Child Abuse

(Mean Scores)

Factor	Mean*
Personality Disorder	2.88
Parent(s) Abused as Child	2.71
Drinking (alcohol)	2.63
Stress	2.50
Maturity of Parents	2.42
Drugs	2.41
Unwanted Child	2.38
Child's Behavior	1.94
Parent's Expectations for the Child	1.85
Unemployment of Father	1.65
Isolation	1.63
Family Financial Status	1.56
Single Parent Family	1.04
Social Class of Family	.79

* 3=Strongly related
0=Unrelated

TABLE 19

Elementary School Principal Ratings of

Causes of Child Abuse

(Mean Scores)

Factor	Mean*
Drinking (alcohol)	2.73
Personality Disorder	2.68
Maturity of Parents	2.47
Drugs	2.44
Unwanted Child	2.36
Stress	2.25
Parent(s) Abused as Child	2.15
Child's Behavior	1.82
Parent's Expectations for the Child	1.69
Unemployment of Father	1.43
Family Financial Status	1.39
Isolation	1.36
Single Parent Family	1.16
Social Class of Family	1.12

* 3=Strongly related
0=Unrelated

TABLE 20

Public Social Worker Ratings

of Causes of Child Abuse

(Mean Scores)

Factor	Mean*
Parent(s) Abused as Child	2.90
Personality Disorder	2.67
Stress	2.57
Maturity of Parents	1.55
Drinking (alcohol)	2.49
Unwanted Child	2.45
Drugs	2.31
Isolation	2.02
Child's Behavior	1.96
Parent's Expectations for the Child	1.84
Unemployment of Father	1.67
Family Financial Status	1.57
Single Parent Family	1.47
Social Class of Family	1.44

* 3=Strongly related
0=Unrelated

TABLE 21

Private Social Worker Ratings

of Causes of Child Abuse

(Mean Scores)

Factor	Mean*
Parent(s) Abused as Child	2.85
Personality Disorder	2.72
Stress	2.63
Maturity of Parents	2.55
Drinking (alcohol)	2.51
Unwanted Child	2.38
Drugs	2.27
Parent's Expectations for the Child	2.13
Isolation	1.84
Child's Behavior	1.82
Family Financial Status	1.55
Unemployment of Father	1.48
Single Parent Family	1.25
Social Class of Family	.89

* 3=Strongly related
0=Unrelated

TABLE 22

Police Ratings of Causes of

Child Abuse

(Mean Score)

Factor	Mean*
Drinking (alcohol)	2.75
Unwanted Child	2.53
Personality Disorder	2.50
Drugs	2.34
Maturity of Parents	2.28
Stress	2.01
Parent(s) Abused as Child	1.99
Child's Behavior	1.85
Family Financial Status	1.53
Unemployment of Father	1.44
Parent's Expectations for the Child	1.43
Single Parent Family	1.30
Isolation	1.26
Social Class of Family	1.16

* 3=Strongly related
0=Unrelated

OCCUPATIONAL ATTITUDES CONCERNING CHILD ABUSE

Our survey of professionals in Rhode Island included questions pertaining to occupational attitudes concerning the various aspects of reporting cases of child abuse, responsibility of reporting and providing services, the consequences of reporting cases of abuse, and the conditions under which individual professionals were likely to report or not report suspected cases of abuse.

Responsibility

Looking for Cases of Child Abuse. A majority of all professionals agreed that it was clearly their responsibility to look for possible cases of child abuse. Physicians, Emergency Room physicians, police officers, and public social workers were in almost complete agreement that they were individually responsible for identifying cases of abuse. School personnel (counselors and principals) and social workers employed in private agencies were less likely to agree that they were responsible for looking for cases of abuse.

Investigating Cases of Suspected Abuse. We asked the respondents whether they agreed or disagreed that they were not responsible for investigating all suspected cases to determine if the child had been abused. Public social workers and Emergency Room physicians disagreed with this statement, indicating that they felt responsible for investigating all cases of suspected abuse. Physicians were the least likely to disagree with the statement, implying that they felt a lesser responsibility to investigate suspected cases of abuse.

Reporting Suspected Cases. Given that an instance of child abuse is suspected, most clinicians and agents of social control agree that they are responsible for reporting the case (in compliance with Rhode Island State

law which mandates reporting by anyone who suspects a child has been abused or neglected). Emergency Room physicians all agreed that they must report, while police officers were almost in total agreement about their responsibility to report. Private social workers were somewhat less likely to feel responsibility to report a suspected case of abuse. This may well be explainable by the fact that many private social workers tended to feel that services could be effectively provided to abused children and their families without going through the formal procedure of reporting the case to the proper agency (see section on treatment for summary of attitudes towards providing treatment and not reporting).

Summary. The three attitudinal questions, taken as a group, indicate that Emergency Room physicians, public social workers, and police officers felt a keen responsibility to look for, investigate, and report suspected cases of child abuse. On the other hand, school personnel and private social workers felt that child abuse identification and reporting is not a central part of their occupational mandate. Private social workers, however, augmented this attitude, by believing that they can still provide services to abusing families without going through the formalities of investigations and reporting. Physicians present a middle ground, agreeing that they should look for cases and acknowledging a responsibility to report cases which they encounter, but, not being particularly interested in investigating suspected cases.

Identifying and Reporting

Interpersonal Relations With the Suspected Abuser. We were interested in learning whether the relations between clinicians and agents of social control and families where abuse might have taken place influences the professional's likelihood of suspecting and/or reporting cases of child abuse. More than thirty percent of the professionals agreed that the more they knew

a family, the less likely they would be to suspect abuse. Physicians and Emergency Room physicians were the most likely to agree that their relations with a family might lessen the likelihood that abuse would be suspected when a child was injured. Social workers employed in both public and private agencies indicated that their relations with families would not be a relevant factor in terms of their identifying an injury as abuse.

When we rephrased the question and asked whether the relationship between professional and family would influence reporting an abuse case, we found that a little less than thirty percent of the respondents agreed that the more impersonal their relation with a family, the more likely they would be to report an injury as abuse. Again, physicians and Emergency Room physicians were among the most likely to report that interpersonal relations would influence their decision to report. Police officers also indicated that they might be influenced by their relations with families. Principals, and social workers were least likely to agree with the statement that impersonal relations heightened the likelihood of their making a report.

A third dimension of the interpersonal relationship was conceptualized as whether or not the professional would ever see the family or child again. Fewer professionals agreed that knowing that they would or would not have to deal with a family again would influence their decision to report a case of child abuse. Once again, medical personnel were more interpersonally sensitive in terms of reporting. Medical personnel were most likely to agree that they would report a case of abuse if they knew that they would not have to deal with that family again. Police officers, private social workers, and principals indicated less agreement with the idea that future contact with a family would influence whether or not a child would be reported as abused.

It would appear that physicians and Emergency Room physicians are the most interpersonally sensitive professionals when it comes to suspecting and

reporting cases of child abuse. Social workers appear to be least influenced by interpersonal relations when they investigate and report abuse cases. However,one should keep in mind when interpreting this and other portions of this section on attitudes, that attitudes are not the same as behaviors; thus, there is no one-to-one relationship between what professionals report in these attitude questions and their actual behavior.

Evidence. We wondered whether the amount of work required to fully investigate a suspected case of child abuse might influence whether a professional would get involved in cases of child abuse. Approximately twenty percent of the respondents agreed that they were reluctant to get involved in cases of child abuse due to the difficulty of gathering evidence. Elementary school counselors were slightly more likely to agree with the statement that they are reluctant to get involved in abuse cases, while police officers and private social workers were least likely to agree with this statement.

Accusations of Abuse. Perhaps the most difficult and sensitive aspect of child abuse investigation and reporting is that a professional may eventually find him or herself faced with having to accuse someone of abusing their child. While this may not always be a face to face confrontation, it does involve potential risks. Only sixteen percent of our respondents thought that they had insufficient power or prestige to actually accuse someone of child abuse. However, school personnel (counselors and principals) were much more prone to agree that they had too little power or presitge to accuse a parent of child abuse. Social workers and Emergency Room physicians did not agree that they lacked enough power or prestige to accuse someone of abuse.

Very few professionals believed that accusing a parent of abuse would hurt their job. School counselors were most likely to agree that their jobs might be hurt if they accused someone of child abuse.

Consequences of Reporting

We were interested in whether various consequences of reporting child abuse cases might influence attitudes of professionals and whether the professionals had ideas about the potential consequences to themselves, the abused child, and the child's family if a case was reported.

Professionals' Relations With the Family. Surprisingly, over half of all professionals responding indicated that they felt that if they reported an abused child, their relationship with the child's family might be undermined. While physicians were the most likely to agree with the statement that reporting would undermine their relations with the child's family, the agreement with the statement was almost uniform across professional groups. If this attitude actually influences behavior in reporting abused children, then this item may well explain why many abused children are not reported. It also indicates that those children who are reported come from families without continuing relations with the clinician or agency of social control making the report.

Losing Control of the Case and Family. Very few professionals thought that they were reluctant to report abused children because reporting the case would mean they (the professionals) would lose the case and not be able to help the child and the family. There was no occupational variation in the responses to this question.

Services to Families. With the exception of social workers employed in private agencies, most respondents thought that reporting child abuse cases would improve the services made available to children and their families. Fewer than fifty percent of the private social workers agreed with this statement. This would seem to indicate that private social workers do not think much of the services provided to families by the state, or they have more faith in the services they can provide, or both.

Consequences for the Child. Almost no one indicated that they would not

report a case of child abuse because of what would happen to the child if the report was made. There was no variation among professionals in response to this item.

Providing Services

In the area of service provision, there was a wide variation in terms of agreeing with whether one's profession was responsible for providing services. Social workers, as would be expected, strongly believed that their profession was responsible for providing services to abused children and their families. Emergency Room physicians, police officers, and principals believed that they were not members of professions mandated with service provision.

There was some variation in the agreement with the statement that services can be provided to families without going through the formal reporting and investigating system. As we stated earlier, private social workers were most likely to agree that they could provide services without reporting the cases to the proper agency. That private social workers felt they could provide services without formal reporting may influence their perception about how important it is to report cases of abuse.

Those professionals who disagreed with the statement that services could be provided without going through the formality of reporting were those professions which had the least resources and training in terms of service provision--Emergency Room physicians, police officers, and physicians.

Causes of Child Abuse

We wanted to use the attitude section of our questionnaire to cross-check the professionals' perceptions of the causes of child abuse. While we asked only one question (because we wanted to keep redundancy in the questionnaire to a minimum) we obtained an interesting variation in responses. When asked if child abuse was the result of a psychological disorder or sickness,

more than sixty percent of the respondents agreed. However, there was considerable variation among professional groups. Physicians, private social workers, and elementary school counselors were the most likely to ascribe the causes of abuse to psychological disorders. Principals, police officers, public social workers, and Emergency Room physicians were less likely to see abuse arising out of psychological factors.

Social Class and Child Abuse

When we asked professionals about the causes of child abuse, we found that "social class" was almost always rated as only weakly related to child abuse. Thus, we were surprised when we found that one-fourth of the respondents agreed that they would be more likely to suspect a low income family of abuse as opposed to a more affluent family. Physicians, Emergency Room physicians, police officers, and principals were the most likely to agree that low income families were more likely to be suspected of abuse. Counselors, and social workers tended not to agree with this statement.

The item concerning low income which the respondents answered was short and might have various interpretations. For instance, given that professionals did not view social class as an important causal factor and that family finances was also not viewed as an important factor, we might interpret the responses as meaning that, irrespective of causal factors, low income families are more vulnerable to being suspected of abusing their children. On the other hand, this item might simply indicate that social class and income are considered important causal factors, despite the low rating received in the section on causes.

TABLE 23

Percent Disagree or Strongly Disagree With Statement:
"It is not my Responsibility to Investigate all Cases of Injured Children to Determine if They Have Been Abused."
by Occupation

Occupational Group	Percent Disagree or Strongly Disagree
Physicians (n=139)	42%
Elementary School Counselors (n=48)	44%
Elementary School Principals (n=107)	50%
Private Social Workers (n=95)	45%
Public Social Workers (n=48)	69%
Emergency Room Physicians (n=9)	67%
Police Officers (n=104)	56%

TABLE 24

Percent Agree or Strongly Agree with Statement

"Looking for Cases of Child Abuse is Part of my Job."

by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=141)	87%
Elementary School Counselors (n=48)	75%
Elementary School Principals (n=109)	75%
Private Social Workers (n=96)	79%
Public Social Workers (n=49)	87%
Emergency Room Physicians (n=9)	89%
Police Officers (n=109)	87%

TABLE 25

Percent Agree or Strongly Agree with Statement:

"If I Suspect a Case of Child Abuse, it is my

Responsibility to Report it."

by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=141)	90%
Elementary School Counselors (n=48)	92%
Elementary School Principals (n=108)	90%
Private Social Workers (n=95)	81%
Public Social Workers (n=49)	96%
Emergency Room Physicians (n=9)	100%
Police Officers (n=102)	98%

TABLE 26

Percent Agree or Strongly Agree With Statement:
"The More I know a Family or Person, the Less Likely I am to Suspect an Injury of a Child as Being Child Abuse."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=143)	46%
Elementary School Counselors (n=48)	25%
Elementary School Principals (n=107)	30%
Private Social Workers (n=93)	11%
Public Social Workers (n=47)	15%
Emergency Room Physicians (n=9)	44%
Police Officers (n=105)	36%

TABLE 27

Percent Agree or Strongly Agree With Statement:
"The More Impersonal my Relationship With Families, the More Likely I am to Report an Injured Child as Abused."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=140)	34%
Elementary School Counselors (n=47)	28%
Elementary School Principals (n=107)	21%
Private Social Workers (n=94)	18%
Public Social Workers (n=49)	20%
Emergency Room Physicians (n=9)	44%
Police Officers (n=104)	38%

TABLE 28

Percent Agree or Strongly Agree With Statement:

"Child Abuse is the Result of a Psychological Disorder or Sickness."

by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=143)	73%
Elementary School Counselors (n=47)	66%
Elementary School Principals (n=108)	45%
Private Social Workers (n=95)	73%
Public Social Workers (n=49)	53%
Emergency Room Physicians (n=9)	55%
Police Officers (n=105)	45%

TABLE 29

Percent Agree or Strongly Agree With Statement:
"I am Reluctant to Pursue the Issue of Child Abuse Because it is Extremely Difficult to Gather Enough Evidence to Warrant Turning the Case Over to the Proper Authorities."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=140)	22%
Elementary School Counselors (n=47)	30%
Elementary School Principals (n=107)	23%
Private Social Workers (n=94)	14%
Public Social Workers (n=49)	18%
Emergency Room Physicians (n=9)	22%
Police Officers (n=104)	16%

TABLE 30

Percent Agree or Strongly Agree With Statement:
"I am More Likely to Report a Case of Child Abuse if I Know I Will not be Dealing With That Family in the Future."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=142)	30%
Elementary School Counselors (n=48)	21%
Elementary School Principals (n=109)	18%
Private Social Workers (n=95)	17%
Public Social Workers (n=48)	30%
Emergency Room Physicians (n=9)	44%
Police Officers (n=105)	16%

TABLE 31

Percent Agree or Strongly Agree With Statement:
"One can Treat Child Abuse Without Going Through the Formal Reporting and Investigation System."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=140)	24%
Elementary School Counselors (n=48)	31%
Elementary School Principals (n=106)	35%
Private Social Workers (n=95)	47%
Public Social Workers (n=49)	27%
Emergency Room Physicians (n=9)	22%
Police Officers (n=104)	21%

TABLE 32

Percent Agree or Strongly Agree With Statement:
"I Feel That I do not Have Enough Power or Prestige to
Accuse Someone of Abusing Their Child."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=138)	14%
Elementary School Counselors (n=48)	33%
Elementary School Principals (n=106)	30%
Private Social Workers (n=94)	5%
Public Social Workers (n=48)	6%
Emergency Room Physicians (n=9)	0%
Police Officers (n=104)	12%

TABLE 33

Percent Agree or Strongly Agree With Statement:

"It Would Hurt my Job if I Were to Accuse Someone of Abusing Their Child."

by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=139)	13%
Elementary School Counselors (n=48)	17%
Elementary School Principals (n=105)	7%
Private Social Workers (n=93)	2%
Public Social Workers (n=49)	6%
Emergency Room Physicians (n=9)	11%
Police Officers (n=103)	5%

TABLE 34

Percent Agree or Strongly Agree With Statement:
"Reporting a Person or Family as an Abuser Might Undermine my Relationship With That Person or Family."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=144)	64%
Elementary School Counselors (n=48)	50%
Elementary School Principals (n=109)	59%
Private Social Workers (n=48)	58%
Public Social Workers (n=48)	56%
Emergency Room Physicians (n=9)	56%
Police Officers (n=105)	55%

TABLE 35

Percent Agree or Strongly Agree With Statement:
"I am Reluctant to Report a Case of Child Abuse
Because the Agency in Charge of Servicing Child Abuse
Will Take on the Case and I Will not be Able to
Help the Family or Child."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=144)	4%
Elementary School Counselors (n=48)	2%
Elementary School Principals (n=106)	3%
Private Social Workers (n=95)	2%
Public Social Workers (n=47)	2%
Emergency Room Physicians (n=9)	0%
Police Officers (n=105)	4%

TABLE 36

Percent Agree or Strongly Agree With Statement:
"Reporting an Abusive Parent and an Abused Child to the Agency Responsible for Child Abuse Will Improve the Services Made Available to the Family."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=144)	75%
Elementary School Counselors (n=48)	69%
Elementary School Principals (n=107)	69%
Private Social Workers (n=95)	48%
Public Social Workers (n=48)	75%
Emergency Room Physicians (n=9)	89%
Police Officers (n=105)	73%

TABLE 37

Percent Agree or Strongly Agree With Statement:

"I Will not Report a Case of Child Abuse Because of

What Will Happen to the Child if the Case is Reported."

by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=144)	2%
Elementary School Counselors (n=48)	2%
Elementary School Principals (n=108)	2%
Private Social Workers (n=95)	0%
Public Social Workers (n=48)	0%
Emergency Room Physicians (n=9)	0%
Police Officers (n=105)	2%

TABLE 38

Percent Agree or Strongly Agree With Statement:

"The Responsibility for Providing Services to Families

Where Child Abuse has Occurred Belongs to my Profession."

by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=139)	50%
Elementary School Counselors (n=48)	50%
Elementary School Principals (n=106)	29%
Private Social Workers (n=95)	90%
Public Social Workers (n=49)	90%
Emergency Room Physicians (n=8)	12%
Police Officers (n=104)	25%

TABLE 39

Percent Agree or Strongly Agree With Statement:
"I am More Likely to Suspect a Low Income Family
of Abusing Their Child Than a More Affluent Family."
by Occupation

Occupational Group	Percent Agree or Strongly Agree
Physicians (n=145)	36%
Elementary School Counselors (n=48)	19%
Elementary School Principals (n=108)	26%
Private Social Workers (n=96)	14%
Public Social Workers (n=49)	16%
Emergency Room Physicians (n=9)	33%
Police Officers (n=105)	32%

SIGNIFICANT FACTORS IN REPORTING CHILD ABUSE

Of the more than 500 professionals who were surveyed, one-fourth had reported at least one case of child abuse in 1975. We asked these professionals to indicate what they considered to be the important factors which prompt them to report a case as abuse. A factor could be rated unimportant; of little importance; some importance, but not enough to prompt the professional to report the case; important, but only in conjunction with other factors, and so important that the professional would report the case based on that factor alone. In analyzing the results of this series of questions we were able to measure the importance of the factor using two indicators. First, we had a mean importance score ranging from a low of zero to a high of five. Secondly, we could assess what percentage of the professionals in each group viewed an item so important that they would report a case and other cases based on this alone.

We assume that the answers provided us by the more than 100 professionals who made child abuse reports in 1975 are influenced by the context in which cases were seen and by the aspects of the cases themselves. We think that it is the context of seeing child abuse cases and the type of cases a professional is likely to come across which influences their "cognitive lens" in assessing injuries in a child and determining whether these are abuse caused injuries or "accidents."

As would be expected when one asks what factors are significant in prompting you to report cases of physical child abuse, the single most important factor was the physical condition of the child. Taking all professionals as a group, this aspect of abuse was rated the most important factor, and 55 percent of the professionals reported that they would file

a report based on the diagnosis of the physical condition of the child in and of itself. The psychological states of the caretaker and the child were rated as the next most salient criterion used in deciding whether to make a child abuse report. This, again, is consistent with the professionals' general outlook that child abuse is caused by psychological malfunctioning in the parent. Given that professionals employ a psychodynamic paradigm to explain child abuse, one would expect the same professionals to predict that abusive parents would exhibit distinctive psychological traits and that the impact of abuse would produce psychological traits in children that would distinguish them from children with similar physical conditions caused by accidents.

The caretaker's behavior and ability to explain the condition of the child were the next two important considerations in deciding whether a child was abused.

The least important traits were social features of the family. Education, occupation, income, housing conditions, race and ethnicity were all rated at the bottom as being of little relevance in deciding to report child abuse. However, one should note that nearly four percent of our survey group indicated that they would (could) report a case of child abuse using race or ethnicity as a single factor. We interpret this as meaning that the child must at least be injured before race and ethnicity become important factors; nevertheless, it does indicate that professionals will base reports of child abuse on social assessments of caretakers and their families.

Physicians

Physicians ranked the physical condition of the child as the most important element in making a decision to file a report and almost 28 percent of the physicians said they would file a report based on an assessment of the child's physical condition alone. The behavior of the caretaker's and their account of how the injury occurred were the next most important factors. Of least concern to physicians were social factors such as occupation and education. However, 5 percent of the doctors would use race and ethnicity as a single factor in reporting an abused child.

In general, physicians appeared to be quite conservative in assessing the importance of factors. Only one item--physical condition of the child, was rated above "four", and no item was important enough for more than 28 percent of the doctors to use as a single factor in filing a report. An interesting finding was that although family composition was not rated as a very crucial item, 15 percent of the physicians said they would use it as the most important single factor in filing an abuse report.

Counselors

Guidance counselors also rated the physical state of the child as the key item prompting them to file a report. More than 60 percent of the counselors would call in an abuse report based on the physical condition of a child only. In keeping with their psychologically oriented training, counselors rated the psychological states of caretaker and child as the next most important elements in assessing if abuse had occurred. A very interesting aspect of the counselors' ratings of items is the low ranking given to a caretaker admitting the child was abused by them. This appears to reflect

how a counselor encounters a case more than the real importance of the item. Most counselors find out about abuse from the child without the parent present. A decision to report a child abuse case typically has to be made with minimal input from the parents. Counselors can draw on previous meetings with the parent to assess psychological traits, but they rarely have a parent admit to them that he or she abused the child.

Principals

Although principals work in the same environment as guidance counselors, they come to their positions with different training and they encounter children in different circumstances. This is reflected in their ranking of items in reporting abused children. Again, physical condition of the child is most important and 2/3 of the principals say they would report on this factor alone. However, psychological traits of caretaker and child are well down principals' list of important traits. Principals react to knowledge of the history of injury, and information provided by others (perhaps other school employees) in making their decisions. Principals are also more sensitive to social factors. Eighteen percent would use family composition, 13 percent would use ethnicity of caretaker, and almost 7 percent would use race as single factors in prompting an abuse report.

Private Social Workers

Private social workers presented a striking difference from the other professional groups. Although more than 60 percent of these professionals indicated that they would use the physical condition of the child as the single important factor in filing a report, the item with the highest mean importance

score was the psychological state of the caretaker/offender. The second most important factor was the psychological state of the child. Caretaker's account of the injury was the third most important factor and physical condition of the child was the fourth most important item. Social factors such as education, income, occupation, race and ethnicity were considered unimportant. Thus, private social workers, more than any other professional group, assess psychological profiles and behavior patterns of caretakers in making their determination if child abuse occurred. This probably reflects their position in the child welfare system. If a child is badly injured, he or she will see a doctor. If the child is mildly injured, the child will be noticed in school. But if the injury is not noticeable, or the abuse is chronic but not especially injurious, the case is likely to turn up in the course of a private social worker's counseling a caretaker or child. In order to uncover such cases, social workers in private settings must focus in on subtle cues rather than overt physical signs or caretaker admissions.

Public Social Workers

Although public social workers typically have similar training to social workers in private agencies, their ratings of importance of factors in reporting child abuse is not at all similar to their counterparts in private agencies. Public social workers rate physical condition of the child, psychological state of the offender, behavior of the caretaker, and previous history of suspicious injury as the leading factors prompting them to file reports. As with private social workers, social traits are unimportant to public social workers in the decision process which leads to filing a report of abuse.

Emergency Room Physicians

Although Emergency Room physicians shared common training with physicians, the context in which they encountered abused children influenced their perception of the phenomenon and the criterion they employed in determining if an injury was caused by a caretaker. The most important factor for an Emergency Room physician was whether there was a history of previous suspicious injury. This factor was considered more salient than the actual physical condition of a child. This probably reflects the fact that ER physicians see numerous injuries which all appear fairly similar. Thus, they cannot use the injury itself as a key factor, they need to determine if the injury is symptom of a more extensive pattern of unexplainable injuries. Thus, the third most important factor was the evaluation of the caretaker's account of how the injury occurred.

Police Officers

The last group, the police, presented an interesting profile of factors. Physical condition of the child, psychological state of parent and child were at the top of the list of important factors while occupation, ethnicity, and race were the least important factors. However, at least some police officers viewed almost every factor (except "behavior of the child") as important enough to base a report of abuse on. In addition, police ranked more factors high on importance than the other professional groups. Lastly, items such as condition of the home and income were considered important enough to base a report on by more police than other professionals.

TABLE 40

All Professionals' Ratings of Importance of Factors Influencing Them in Reporting Cases of Child Abuse

Factor	Mean Importance	% Indicating Factor so Important That They Would Report on This Alone
Physical Condition of the Child (n=100)	4.39	55
Psychological State of Suspected Offender (n=90)	4.06	32.2
Psychological State of the Child (n=100)	3.82	29
Evaluation of Caretaker's Account of Cause of Injury (n=110)	3.82	15.5
Behavior of Caretakers (n=95)	3.77	17.9
Previous History of Suspicious Injury (n=109)	3.70	22.9
Someone Other Than the Caretaker Informed About Abuse (n=114)	3.67	19.3
Caretaker's Admission of Causing Injury (n=106)	3.6	35.8
Behavior of the Child (n=92)	3.23	6.5
Caretaker's Cooperativeness (n=109)	3.04	4.6
Condition at Home (n=91)	2.92	9.9
Family Size (n=110)	2.11	2.7
Family Composition (n=107)	2.11	14
Education of the Caretaker (n=110)	1.9	0.9
Income of Caretaker (n=110)	1.87	1.8
Occupation of Caretaker (n=110)	1.68	0.9
Ethnicity of Caretaker (n=109)	1.46	4.6
Race of Caretaker (n=109)	1.36	3.7

TABLE 41

Physicians' Ratings of Importance of Factors Influencing Them in Reporting Cases of Child Abuse

Factor	Mean Importance	% Indicating Factor so Important That They Would Report on This Alone
Physical Condition of the Child (n=18)	4.17	27.8
Behavior of Caretakers (n=15)	3.66	6.7
Evaluation of Caretaker's Account of Cause of Injury (n=19)	3.57	5.3
Psychological State of Suspected Offender (n=13)	3.53	0
Caretaker's Admission of Causing Injury (n=19)	3.32	26.3
Psychological State of the Child (n=20)	3.20	0
Caretaker's Cooperativeness (n=20)	3.15	0
Behavior of the Child (n=17)	3.00	0
Someone Other Than the Caretaker Informed About Abuse (n=19)	2.89	0
Previous History of Suspicious Injury (n=21)	2.85	9.5
Condition of the Home (n=15)	2.33	0
Family Composition (n=19)	2.10	15.8
Education of the Caretaker (n=20)	2.00	0
Income of the Caretaker (n=20)	1.75	0
Family Size (n=20)	1.75	0
Occupation of Caretaker (n=20)	1.70	0
Race of Caretaker (n=20)	1.45	5
Ethnicity of Caretaker (n=20)	1.45	5

TABLE 42

Counselors' Ratings of Importance of Factors Influencing Them in Reporting Cases of Child Abuse

Factor	Mean Importance	% Indicating Factor so Important That They Would Report on This Alone
Physical Condition of the Child (n=11)	4.55	63.6
Psychological State of the Child (n=12)	4.08	41.7
Psychological State of Suspected Offender (n=11)	4.00	27.3
Previous History of Suspicious Injury (n=13)	3.92	23.1
Someone Other than the Caretaker Informed About Abuse (n=14)	3.71	21.4
Evaluation of Caretaker's Account of Cause of Injury (n=13)	3.61	0
Behavior of Caretakers (n=10)	3.40	10.0
Behavior of the Child (n=9)	3.22	22.2
Caretaker's Admission of Causing Injury (n=13)	2.92	30.8
Condition of the Home (n=9)	2.88	22.2
Caretaker's Cooperativeness (n=12)	2.83	0
Family Size (n=12)	2.33	0
Family Composition (n=11)	2.09	9.1
Education of Caretaker (n=12)	1.66	0
Income of Caretaker (n=12)	1.66	0
Occupation of Caretaker (n=12)	1.58	0
Ethnicity of Caretaker (n=12)	1.33	0
Race of Caretaker (n=12)	1.16	0

TABLE 43

Principals' Ratings of Importance of Factors Influencing Them in Reporting Cases of Child Abuse

Factor	Mean Importance	% Indicating Factor so Important That They Would Report on This Alone
Physical Condition of the Child (n=15)	4.67	66.7
Previous History of Suspicious Injury (n=15)	3.93	13.3
Someone Other Than the Caretaker Informed About Abuse (n=16)	3.81	18.8
Evaluation of Caretaker's Account of Cause of Injury (n=16)	3.81	12.5
Behavior of Caretakers (n=15)	3.60	26.7
Psychological State of Suspected Offender (n=12)	3.58	33.3
Psychological State of the Child (n=17)	3.53	29.4
Behavior of the Child (n=11)	3.18	9.1
Condition of the Home (n=13)	3.00	15.4
Caretaker's Cooperativeness (n=16)	2.93	0
Caretaker's Admission of Causing Injury (n=11)	2.91	27.3
Family Size (n=16)	2.18	0
Education of the Caretaker (n=16)	2.00	0
Occupation of Caretaker (n=16)	1.93	0
Income of Caretaker (n=16)	1.93	0
Family Composition (n=16)	1.87	18.8
Ethnicity of Caretaker (n=15)	1.53	13.3
Race of Caretaker (n=15)	1.46	6.7

TABLE 44

Private Social Workers' Ratings of Importance of Factors Influencing Them in Reporting Cases of Child Abuse

Factor	Mean Importance	% Indicating Factor so Important That They Would Report on This Alone
Psychological State of Suspected Offender (n=19)	4.47	47.4
Psychological State of the Child (n=14)	4.36	42.9
Evaluation of Caretaker's Account of Cause of Injury (n=18)	4.35	33.3
Physical Condition of the Child (n=16)	4.19	62.5
Behavior of Caretakers (n=12)	4.12	16.7
Caretaker's Admission of Causing Injury (n=19)	3.89	36.8
Someone Other Than the Caretaker Informed About Abuse (n=17)	3.76	29.4
Behavior of the Child (n=13)	3.62	7.7
Previous History of Suspicious Injury (n=17)	3.29	11.8
Caretaker's Cooperativeness (n=17)	3.17	11.8
Condition of the Home (n=14)	3.14	0
Family Composition (n=14)	2.11	11.8
Family Size (n=19)	2.05	5.3
Education of the Caretaker (n=18)	1.5	0
Income of Caretaker (n=18)	1.44	0
Occupation of Caretaker (n=18)	1.27	0
Race of Caretaker (n=18)	1.22	0
Ethnicity of Caretaker (n=18)	1.22	0

TABLE 45

Public Social Workers' Ratings of Importance of Factors Influencing Them in Reporting Cases of Child Abuse

Factor	Mean Importance	% Indicating Factor so Important That They Would Report on This Alone
Physical Condition of the Child (N=12)	4.25	50.0
Psychological State of Suspected Offender (n=12)	4.25	33.3
Behavior of Caretakers (n=12)	4.16	16.7
Previous History of Suspicious Injury (n=13)	4.15	38.5
Evaluation of Caretaker's Account of Cause of Injury (n=14)	4.07	21.4
Someone Other Than the Caretaker Informed About Abuse (n=14)	4.0	7.1
Caretaker's Admission of Causing Injury (n=13)	3.92	46.2
Psychological State of the Child (n=13)	3.85	23.1
Behavior of the Child (n=13)	3.53	7.7
Caretaker's Cooperativeness (n=14)	3.14	0
Condition of the Home (n=14)	3.14	0
Family Size (n=14)	2.35	0
Family Composition (n=14)	2.78	21.4
Education of the Caretaker (n=14)	1.85	0
Income of Caretaker (n=14)	1.64	0
Occupation of Caretaker (n=14)	1.57	0
Ethnicity of Caretaker (n=14)	1.42	0
Race of Caretaker (n=14)	1.35	0

TABLE 46

Emergency Room Physicians' Ratings of Importance of Factors Influencing Them in Reporting Cases of Child Abuse

Factor	Mean Importance	% Indicating Factor so Important That They Would Report on This Alone
Previous History of Suspicious Injury (n=4)	4.75	*
Physical Condition of the Child (n=5)	4.60	
Evaluation of Caretaker's Account of Cause of Injury (n=4)	4.25	
Psychological State of Suspected Offender (n=2)	4.0	
Someone Other Than the Caretaker Informed About Abuse (n=5)	3.8	
Psychological State of the Child (n=4)	3.75	
Behavior of the Child (n=3)	3.65	
Caretaker's Admission of Causing Injury (n=5)	3.60	
Family Size (n=4)	2.75	
Family Composition (n=4)	2.75	
Behavior of Caretakers (n=3)	2.66	
Education of the Caretaker (n=4)	2.5	
Occupation of Caretaker (n=4)	2.5	
Income of Caretaker (n=4)	2.5	
Condition of the Home (n=2)	2.5	
Caretaker's Cooperativeness (n=4)	2.25	
Ethnicity of Caretaker (n=4)	2.75	
Race of Caretaker (n=4)	1.5	

*insufficient number of cases to compute

TABLE 47

Police Officers' Ratings of Importance of Factors Influencing Them in Reporting Cases of Child Abuse

Factor	Mean Importance	% Indicating Factor so Important That They Would Report on This Alone
Physical Condition of the Child (n=23)	4.48	60.9
Psychological State of Suspected Offender (n=21)	4.23	38.1
Psychological State of the Child (n=20)	4.15	40
Caretaker's Admission of Causing Injury (n=26)	4.08	38.5
Previous History of Suspicious Injury (n=26)	4.03	30.8
Someone Other Than the Caretaker Informed About Abuse (n=29)	3.83	27.6
Behavior of the Caretakers (n=24)	3.83	20.8
Evaluation of Caretaker's Account of Cause of Injury (n=26)	3.57	15.4
Condition of the Home (n=23)	3.52	21.7
Caretaker's Cooperativeness (n=26)	3.11	11.5
Behavior of the Child (n=23)	2.95	0
Income of Caretaker (n=26)	2.15	7.7
Education of the Caretaker (n=26)	2.11	3.8
Family Size (n=25)	2.08	8.0
Family Composition (n=26)	2.07	7.7
Occupation of Caretaker (n=26)	1.76	3.87
Ethnicity of Caretaker (n=26)	1.57	7.7
Race of Caretaker (n=26)	1.42	7.7

REPORTING CHILD ABUSE

The more than 500 professionals in our survey reported 457 cases of child abuse to the Rhode Island Department of Social and Rehabilitative Services, Child Protection Unit in 1975. Since there are no accurate statistics available on how many cases of child abuse were reported to the Child Protection Unit in 1975, we cannot determine what percent of the total number of reports 457 represents. We do know that the State of Rhode Island reported that they serviced approximately 250 valid reports of child abuse and neglect in 1975.

The most cases were reported by private social workers (see Table 48). The least number of cases were reported by Emergency Room physicians. Considering the ratio between number of professionals and number of cases reported, Emergency Room physicians report the most cases per professional while elementary school principals report the least number of cases per professional.

Half of all Emergency Room physicians reported abused children to the state, while only 15% of physicians in private practice filed reports. In the elementary schools, counselors were more likely to file reports, while public social workers are more likely to report abuse than private social workers.

Actual cases reported does not exhaust the number of possible cases of child abuse actually seen by professionals. The Rhode Island State Child Abuse Law mandates that all citizens must report any case of suspected child abuse. An examination of Table 49 reveals that, with the exception of Emergency Room physicians and police officers, less than half of the members of the professional groups surveyed comply with the state child abuse law. In all, of the 1,393 cases of child abuse suspected by members of the seven

professions, only 457 were actually reported. In other words, only one of three suspected cases of child abuse was reported by the professionals we studied in 1975.

Emergency Room physicians are most likely to report cases of abuse which they suspect, while private social workers are least likely. In part, this may be explained by the nature of the abuse. Abuse seen by Emergency Room physicians is likely to be physical trauma. But, as seen in the earlier discussion and as was revealed in the interviews with professionals, Emergency Room physicians are more likely to have a lower class clientele and have more social distance from the children and families they encounter.

Another explanation why cases are not reported is that the professional who identified the case will attempt to treat the case without going through the formal reporting network. While private social workers report only 14% of the cases they suspect, they treat 60% of the 530 cases they suspect but do not report (see Table 50). Likewise, physicians treat 77%, counselors treat 65%, principals treat 51%, public social workers treat 78%, and police treat 44% of the cases they suspect but do not report.

TABLE 48

REPORTING OF CHILD ABUSE CASES TO CHILD PROTECTION UNIT

IN 1975 BY OCCUPATION

OCCUPATION	% REPORTING	# CASES REPORTED	# CASES REPORTED/ # IN OCCUPATION
Physicians (N=143)	15%	74	.52
Elementary School Counselors (N=44)	30%	45	1.02
Elementary School Principals (N=99)	19%	50	.51
Private Social Workers (N=91)	24%	87	.88
Public Social Workers (N=45)	36%	85	1.89
Emergency Room Physicians (N=8)	50%	34	4.25
Police Officers (N=96)	34%	82	.85
TOTAL (N=526)	25%	457	.87

TABLE 49

NUMBER OF CHILD ABUSE CASES SUSPECTED AND REPORTED IN 1975 BY OCCUPATION

OCCUPATION	# OF CASES SUSPECTED	# OF CASES REPORTED	% OF SUSPECTED CASES THAT ARE REPORTED
Physicians	173	74	43%
Elementary School Counselors	123	45	37%
Elementary School Principals	133	50	38%
Private Social Workers	617	87	14%
Public Social Workers	181	85	47%
Emergency Room Physicians	34	34	100%
Police Officers	132	82	62%
TOTAL	1393	457	33%

TABLE 50

CHILD ABUSE CASES SUSPECTED, TREATED*, BUT NOT REPORTED IN 1975 BY OCCUPATION

OCCUPATION	% SUSPECTED AND TREATED*	# CASES SUSPECTED AND TREATED*	# CASES SUSPECTED AND TREATED*/ # IN OCCUPATION
Physicians (N=140)	11%	76	.54
Elementary School Counselors (N=44)	41%	51	1.16
Elementary School Principals (N=99)	21%	43	.43
Private Social Workers (N=90)	52%	320	3.56
Public Social Workers (N=46)	22%	75	1.63
Emergency Room Physicians (N=8)	0%	0	--
Police Officers (N=96)	8%	22	.23
TOTAL (N=523)	23	587	1.12

* Tried to get medical, psychological, or social assistance for the individual.

TABLE 51

CHILD ABUSE CASES SUSPECTED BUT NOT REPORTED IN 1975 BY OCCUPATION

OCCUPATION	% SUSPECTING BUT NOT REPORTED OR TREATED	# CASES SUSPECTED BUT NOT REPORTED OR TREATED	# CASES/# IN OCCUPATION
Physicians (N=141)	9%	23	.16
Elementary School Counselors (N=44)	30%	27	.61
Elementary School Principals (N=99)	19%	40	.40
Private Social Workers (N=89)	38%	210	2.36
Public Social Workers (N=46)	7%	21	.46
Emergency Room Physicians (N=9)	0%	0	--
Police Officers (N=96)	12%	28	.20
TOTAL (N=524)	8%	349	.67

KNOWLEDGE OF THE LAW

A sidebar of our research on defining and classifying cases of child abuse was our assessment about the knowledge in the community concerning the child abuse law, who to report a case to, and how. We found that, with the exception of Public and Private Social Workers, there was a general lack of knowledge about which agent or agency should receive reports of child maltreatment. Elementary School counselors were the most knowledgable--69% knew to call the Child Welfare Division of the Department of Social and Rehabilitative Services. Less than half of the Elementary School principals and physicians knew which agency was mandated to receive abuse and neglect reports. Overall, only 6 in 10 professionals in the state correctly named the appropriate agency to report child abuse cases to (see Table 52).

Only one in five professionals in the state of Rhode Island could correctly list the telephone number of the agency which received child abuse reports. This figure is surprisingly low since 60% of the professionals knew the agency which received reports, and the respondents could have looked up the number in a telephone book while completing the questionnaire. No Emergency Room physician knew the telephone number, only 6% of the physicians knew the number, and 18% of the public social workers could not identify the number of their own employer which should be used to make a child abuse report (Table 53).

Lastly, we constructed a nine question quiz on the Rhode Island child abuse law (see Appendix A). Of the 565 professionals completing the quiz, the average score was 57%. Public social workers scored the best--getting an average of 78% of the questions right. Elementary School principals did the poorest, getting an average of 46% correct. In all, only the social workers would have passed the quiz if we used a standard 90, 80, 70, 60, 50 curve for

grading the results (Table 54).

The results of our survey on knowledge of the law and which agency is delegated the responsibility to receive child abuse reports clearly indicates a pressing need for continued in-service education about child abuse and neglect. Even if a professional knows about a case of child abuse, ignorance of the laws and procedures will hamper that professional's attempt to get help and assistance for the child.

TABLE 52

Percent Correctly Identifying Agency

Delegated With the Responsibility

Of Investigating Reports of Child Abuse

Occupational Groups	Percent Correctly Identifying Agency
Physicians (n=131)	45%
Elementary School Counselors (n=45)	69%
Elementary School Principals (n=97)	43%
Private Social Workers (n=93)	90%
Public Social Workers (n=49)	100%
Emergency Room Physicians (n=9)	56%
Police Officers (n=95)	50%
Total (n=513)	61%

TABLE 53

Percent Knowing Telephone Number to

Call to Report Child Abuse

Occupational Groups	Percent Knowing Telephone Number
Physicians (n=126)	6%
Elementary School Counselors (n=45)	33%
Elementary School Principals (n=97)	13%
Private Social Workers (n=93)	27%
Public Social Workers (n=49)	82%
Emergency Room Physicians (n=8)	0%
Police Officers (n=95)	3%
Total (n=513)	20%

TABLE 54

Mean Percent Questions About

Child Abuse Law

Answered Correctly

Occupational Groups	Mean Percent Questions Answered Correctly
Physicians (n=148)	58%
Elementary School Counselors (n=48)	57%
Elementary School Principals (n=109)	46%
Private Social Workers (n=96)	61%
Public Social Workers (n=49)	78%
Emergency Room Physicians (n=9)	57%
Police Officers (n=106)	56%
Total (n=565)	57%

DISCUSSION

Although our analysis of the data on defining and classifying child abuse is very elementary, we see the data pointing to some important implications for understanding child abuse and for understanding the kinds of problems which might be encountered in programs aimed at predicting child abuse and neglect.

Our 500 professionals represent a cross-section of clinicians who deal with child abuse in one state. As individuals and as aggregate groups of professionals, they represent an average level of knowledge and comprehension about child abuse. They have attended some conferences and workshops on child abuse and have read some material on the topic in the public media and their own professional publications.

In terms of defining child abuse, there were some behaviors which received near unanimous agreement as to whether they were or were not abuse. However, there was considerable variance within and between professional groups as to what child abuse is. The implications for predicting child abuse and neglect would appear to be that if we are to predict abuse and neglect of children we would require a rigorous definition of what child abuse and neglect is before any predictive instrument could be fruitfully employed. Without such a definition, we could not begin to predict the phenomenon we refer to as "child abuse;" instead, we would be predicting a variety of phenomenon based on the professional training, experience, organizational contexts, and perceptual framework of various professionals and professional groups.

The data on causes of child abuse and factors used in diagnosing cases illustrates that the psychodynamic framework is the predominant "cognitive lens" used in identifying and labeling cases of child abuse.

The implications of the widespread reliance on the psychodynamic framework are obvious. If clinicians view child abuse as being caused by

psychological problems and if they rely on psychological inventories of parents and children as key items to discriminate between abuse and accidental injury, then the children who are identified as abused and the families identified as abusers will typically be those who have members whose behavior departs from the expected norm. Thus, a caretaker who can present a a reasonable presentation of self and can provide a reasonable accounting of the child's injury will escape detection.

A second implication of the use of "cognitive lenses" in detecting child abuse is the potential for false positive diagnoses. Our examination of the factors used by physicians in evaluating possible cases of child abuse illustrated that physicians rate the behavior of caretakers and the caretakers' accounts of the injury as the second and third most important factors in classifying cases of abuse. An interview with a physician provided information about how these factors can lead to a false positive diagnosis:

> "The case involved a child of 2 years of age who was brought by his parents to the Emergency Room with numerous contusions and black and blue marks. The parents were high school drop outs and were very uncomfortable with the nurses and the physicians. When we asked them how the child was hurt, they said, "he falls down a lot." The child was examined, x-rayed, treated and released. About a month later the child was back with the same injuries and the parents again said "he fell down." Well by this time we were suspicious so we called Child Welfare to come and investigate. While they were investigating we found out that the kid was almost blind. His vision was so poor that everything must have looked like a shadow to him. No wonder he bumped into things and fell down. We gave him glasses like "Coke-bottle bottoms." It was scary--the parents almost lost the kid."

False positive diagnoses are going to be made, even by the best trained clinicians. The kinds of false positives will vary depending on the "cognitive lens" employed by the clinician.

Footnotes

1. There is a logical contradiction contained in the paper which is unavoidable. On the one hand, we begin the paper by stating that there is no objective condition which can be called "child abuse," while later in the paper we refer to errors in predicting and labeling "child abuse." How can we claim that people make errors if we argue there is no category "child abuse"? The solution to this dilemma is to admit that we believe that some actions of caretakers are, in fact abusive. The point of our research is that the cases which are labeled "child abuse" vary according to many social, psychological, and situational factors. While there will probably never be a precise definition of abuse based on the objective properties of an act or acts. It might be advisable for the reader to assume quotation marks appear each time we refer to the concept "child abuse".

References

Gelles, Richard J.
1975 "The social construction of child abuse." American Journal of Orthopsychiatry 45(April):363-371.

Zigler, Edward
1976 "Controlling child abuse in America: An effort doomed to failure." Paper presented at the First National Conference on Child Abuse and Neglect, Atlanta.

APPENDIX A

CHILD ABUSE

IN

RHODE ISLAND

Research Project

Please fill out the questionnaire and return it in the stamped envelope which is supplied. Thank you for your cooperation.

1. Briefly define (using your own words) what you believe to be "child abuse."

_____

_____

_____

_____

_____

_____

2. Which of the following conditions do you consider to be child abuse? (Check appropriate box for each item.)

	Yes	No	Undecided
a. Child has received willfully inflicted trauma frequently by a parent or guardian.	___	___	___
b. Child has been injured due to careless child care by parents.	___	___	___
c. Lack of emotional and intellectual stimulation of child by parents.	___	___	___
d. Malnutrition due to willful withholding of foods by parents.	___	___	___
e. Malnutrition due to parental ignorance about proper diet.	___	___	___
f. Malnutrition due to parents' financial inability to purchase proper foods.	___	___	___
g. Overfeeding by parents which causes obesity in the child.	___	___	___
h. Child is injured when struck too hard by parent in course of punishing child.	___	___	___
i. Health services (e.g. immunization, nutrition, regular check-ups) not available to child due to inadequate social distribution of health care.	___	___	___
j. Child injured due to poor conditions of housing.	___	___	___
k. Sexual molestation of a child.	___	___	___
l. Locking a child in a dark room or closet as punishment.	___	___	___

	Yes	No	Undecided
m. Not providing adequate precaution to prevent child's accidental injury (e.g. gates on stairs, putting medicine or poisons out of reach, etc.)	___	___	___

n. Other (please specify)_____

_____

_____

_____

_____

IN THE FOLLOWING SERIES OF QUESTIONS WE ARE INTERESTED IN LEARNING ABOUT YOUR ATTITUDES AND OPINIONS ABOUT CHILD ABUSE AND YOUR OWN RESPONSIBILITIES IN DEALING WITH CHILD ABUSE.

For each statement circle the appropriate number which best represents your level of agreement with the statement.

1=strongly agree
2=agree
3=undecided
4=disagree
5=strongly disagree

3. Looking for cases of child abuse is part of my job.	1	2	3	4	5
4. It is not my responsibility to investigate all cases of injured children to determine if they have been abused.	1	2	3	4	5
5. If I suspect a case of child abuse, it is my responsibility to report it.	1	2	3	4	5
6. One can treat child abuse without going through the formal reporting and investigating system.	1	2	3	4	5
7. The responsibility for providing services to families where child abuse has occurred belongs to my profession.	1	2	3	4	5
8. I feel that I do not have enough power or prestige to accuse someone of abusing their child.	1	2	3	4	5
9. It would hurt my job if I were to accuse a person of abusing their child.	1	2	3	4	5
10. The more impersonal my relationships with families the more likely I am to report an injured child as abused.	1	2	3	4	5
11. I am reluctant to pursue the issue of child abuse because it is extremely difficult to gather enough evidence to warrant turning the case over to the proper authorities.	1	2	3	4	5

1=strongly agree
2=agree
3=undecided
4=disagree
5=strongly disagree

12. I am more likely to suspect a low income family of abusing their child than a more affluent family. 1 2 3 4 5

13. The more I know a family or person, the less likely I am to suspect an injury of a child as being child abuse. 1 2 3 4 5

14. Child abuse is the result of psychological disorder or sickness. 1 2 3 4 5

15. Reporting a person or family as an abuser might undermine my relationship with that person or family. 1 2 3 4 5

16. I am more likely to report a case of child abuse if I know I will not be dealing with that family in the future. 1 2 3 4 5

17. Reporting an abusive parent and abused child to the agency responsible for child abuse will improve the services made available to that family. 1 2 3 4 5

18. I will not report a case of child abuse because of what will happen to the child if the case is reported. 1 2 3 4 5

19. I am reluctant to report a case of child abuse because the agency in charge of servicing child abuse will take on the case and I will not be able to help the family or child. 1 2 3 4 5

(GO TO NEXT PAGE)

20. FOR THE PURPOSES OF THIS QUESTION WE WOULD LIKE YOU TO THINK OF "CHILD ABUSE" AS BEING ONLY INSTANCES WHERE A PARENT HAS INFLICTED A PHYSICAL INJURY TO A CHILD. GIVEN THIS DEFINITION OF ABUSE, WE WOULD LIKE TO KNOW WHAT YOU BELIEVE TO BE THE CAUSES OF CHILD ABUSE.

For each item, circle the appropriate number which best indicates how strongly a factor is related as a cause of child abuse.

	0=Unrelated 1=Weakly related 2=Somewhat related 3=Strongly related
a. Maturity of parent or parents	0 1 2 3
b. Whether child was wanted by parent or parents	0 1 2 3
c. Drinking (alcohol)	0 1 2 3
d. Family financial status	0 1 2 3
e. Personality disorder of parent or parents	0 1 2 3
f. Unemployment of father	0 1 2 3
g. Parent's expectations for the child	0 1 2 3
h. Parent(s) abused as child	0 1 2 3
i. Child's behavior	0 1 2 3
j. Isolation from relatives or other friends	0 1 2 3
k. Drug usage	0 1 2 3
l. Stress on family	0 1 2 3
m. Single parent family	0 1 2 3
n. Social class of family	0 1 2 3

The following questions are designed to measure your current knowledge about child abuse in Rhode Island. Please answer as candidly and as thoroughly as you are able.

21. There were approximately _____ reported cases of child abuse in Rhode Island in 1975.

22. The agency delegated the responsibility for investigating cases of child abuse and providing services for those families is _____.

23. A social worker or other person who suspects that a child has been abused can call the following telephone number: _____ to report the suspected case.

24. How many cases of child abuse do you think occurred in Rhode Island in 1975? _____

The following questions are designed to measure your current knowledge about the laws in Rhode Island pertaining to battered and abused children. Please check either T(True) or F(False) for each statement which follows:

	T	F	Don't Know
25. Only physicians, social workers, and school personnel are required to report suspected cases of child abuse.	___	___	___
26. There is no penalty for failing to report a suspected case of child abuse to the proper agency.	___	___	___
27. A physician treating an abused child has the right to keep the child in the custody of the hospital for up to 72 hours without the consent of the child's parents or guardian.	___	___	___
28. A person who reports a case of child abuse must be able to prove that the child was abused.	___	___	___
29. Any individual making a report of child abuse which cannot be proven in a court of law is liable to criminal and/or civil prosecution.	___	___	___
30. The privilege of physician-patient confidentiality does not pertain to legal proceedings in cases of petitions for removal of abused children.	___	___	___
31. The Rhode Island law on battered and abused children includes sexual molestation and malnutrition under the definition of child abuse.	___	___	___
32. When a suspected case of child abuse is reported, the child is automatically removed from the family.	___	___	___
33. A physician, social, worker, or other person making a report of suspected child abuse will have to appear in court to testify in proceedings to determine if abuse did occur.	___	___	___

THIS SECTION DEALS WITH YOUR OWN EXPERIENCE WITH CASES OF CHILD ABUSE IN YOUR WORK.

In the last 12 months, in your work, how many cases of child abuse (using your own definition) have you:

34. Reported to the appropriate agency _____

35. Suspected, but did not report _____

36. Suspected, did not report, but tried to get medical, psychological, or social assistance for _____

ANSWER THE NEXT QUESTION ONLY IF YOU REPORTED A CASE OF CHILD ABUSE IN 1975. IF YOU DID NOT REPORT A CASE TURN TO QUESTION 38, PAGE 9

37. In the course of identifying the case or cases which you reported there may have been a variety of factors or indicators which prompted you to decide to report the case(s). Circle the appropriate number which best indicates how important a factor was in the final decision to report a case. (NOTE:) If you reported more than one case, answer this question in terms of the general factors associated with all the cases you reported.

0=Unimportant
1=Little importance
2=Some importance, but not enough to prompt me to report the case.
3=Important, but only in conjunction with other factors was it important enough to cause me to report the case.
4=So important that I would report this and other cases on the basis of this alone.

A. Parent or caretaker told me he/she inflicted the injury or caused the condition. 0 1 2 3 4

B. Someone other than the parent or caretaker told me parent or caretaker inflicted the injury or caused the condition. 0 1 2 3 4

C. Physical state of child. 0 1 2 3 4

Nature of condition: _____

_____

_____

How determined: _____

_____

_____

D. Psychological state of the child. 0 1 2 3 4

Nature of condition: _____

0=Unimportant
1=Little importance
2=Some importance, but not enough to prompt me to report the case.
3=Important, but only in conjunction with other factors was it important enough to cause me to report the case.
4=So important that I would report this and other cases on the basis of this alone.

How determined:_____

_____

_____

_____

E. Psychological state of person suspected of causing injury or condition. 0 1 2 3 4

Nature of condition:_____

_____

_____

_____

How determined:_____

_____

_____

_____

F. Your own evaluation of the parent s or caretaker's account of how the child's injury was caused. 0 1 2 3 4

G. Cooperativeness of child's parents or caretakers. 0 1 2 3 4

H. Previous history of suspicious injuries to child. 0 1 2 3 4

I. Social characteristics of caretaker:

i. Race 0 1 2 3 4

ii. Education 0 1 2 3 4

iii. Occupation 0 1 2 3 4

iv. Income 0 1 2 3 4

v. Ethnicity 0 1 2 3 4

0=Unimportant
1=Little importance
2=Some importance but not enough to prompt me to report the case.
3=Important, but only in conjunction with other factors was it important enough to cause me to report the case.
4=So important that I would report this and other cases on the basis of this alone.

J. Family Size (number of other children) 0 1 2 3 4

K. Family composition (single parent family) 0 1 2 3 4

L. Behavior of child 0 1 2 3 4

Describe: _____

_____

_____

M. Behavior of parents 0 1 2 3 4

Describe: _____

_____

_____

_____

N. Condition of Home or Apartment 0 1 2 3 4

Describe: _____

_____

_____

_____

O. Other (please specify) 0 1 2 3 4

_____

_____

_____

_____

(GO TO NEXT PAGE)

ANSWER QUESTIONS 38-40 ONLY IF YOU SUSPECTED A CASE OF CHILD ABUSE IN YOUR WORK BUT DID NOT REPORT IT. IF YOU DID NOT SUSPECT A CASE, TURN TO NEXT PAGE.

38. What factors (from question 37) were present which made you suspect child abuse?

_____

_____

_____

_____

39. What factors (from question 37) were absent which made you decide not to report the case as child abuse?

_____

_____

_____

_____

40. What other factors influenced your decision not to report suspected case or cases of child abuse?

_____

_____

_____

_____

(GO TO NEXT PAGE)

41. Have you read any books or articles on the topic of child abuse?

Yes____ No____

42. Please list the books or articles you read:

_____

_____

_____

_____

43. Have you attended any lectures, seminars, or workshops on child abuse?

Yes____ How Many_____ No____

44. Have your attitudes about child abuse changed as a result of these readings or seminars?

Yes____ No____

45. If your attitudes have changed, briefly explain how:_____

_____

_____

(GO TO NEXT PAGE)

46. Please answer the following five questions by circling the appropriate number.

1=A great deal
2=Some
3=A little
4=None at all
5=Not applicable

A.	How much job or occupational power do you have in your present position?	1	2	3	4	5
B.	How much power do you have when you deal with people in the course of your daily work?	1	2	3	4	5
C.	How much prestige do you feel your job or position brings to you?	1	2	3	4	5
D.	How much decision making responsibility do you have in your daily work?	1	2	3	4	5
E.	How much control do you have over your work conditions?	1	2	3	4	5

47. YOUR RELIGIOUS PREFERENCE (Check appropriate box)

Roman Catholic_____

Eastern Orthodox_____

Baptist_____

Lutheran_____

Methodist_____

Presbyterian_____

Other Protestant (Please specify)_____

Jewish_____

Other (please specify)_____

None_____

48. In what size town or city do you practice medicine?

___Rural (in open country, farmland, etc.) population under 2,500

___Small city or town, population under 50,000

___Medium city, population between 50,000 to 250,000

___Large city, population over 250,000

___Suburn near a large city

49. Approximately, how many patients do you see per week? _____

50. How many years have you practiced medicine? _____

51. Do you have an affiliation with one or more hospitals?

Yes ____ No ____

52. Did you receive your medical training in the United States?

Yes ____ No ____

53. What year did you complete medical school? _____

54. Age at last birthday? _____

55. Sex Male ____ Female ____

56. Race (check appropriate box)

White ____

Black ____

Oriental ____

American Indian ____

Other (please specify) ____

57. What is your medical specialty? _____

Principal

48. In what size town or city do you work?

____Rural (in open country, farmland, etc.) population under 2,500

____Small city or town, population under 50,000

____Medium city, population between 50,000 to 250,000

____Large city, population over 250,000

____Suburb near a large city

49. Approximately how many students do you see in your office per week?_____

50. How many years have you been a principal? _____

51. Were you employed in a school system before you became a principal?

Yes _____ Position:_____ # Years _____

_____ _____

_____ _____

_____ _____

No _____

52. What is the highest degree you hold? _____

53. In what year did you receive that degree? _____

54. Age at last birthday? _____

55. Sex Male _____ Female _____

56. Race (check appropriate box)

White _____

Black _____

Oriental _____

American Indian _____

Other (please specify) _____

Social Worker

48. In what size town or city do you work?

____Rural (in open country, farmland, etc.) population under 2,500

____Small city or town, population under 50,000

____Medium city, population between 50,000 to 250,000

____Large city, population over 250,000

____Suburb near a large city

49. Approximately, how many clients do you see per week? _____

50. How many years have you been a social worker?_____

51. What is the highest degree you hold? _____

52. In what year did you receive that degree?_____

53. Age at last birthday? _____

54. Sex Male_____ Female _____

55. Race (check appropriate box)

White ____

Black ____

Oriental ____

American Indian ____

Other (please specify) _____

56. What is your exact job title? _____

_____

ER MD

48. In what size town or city do you practice medicine?

____Rural (in open country, farmland, etc.) population under 2,500

____Small city or town, population under 50,000

____Medium city, population between 50,000 to 250,000

____Large city, population over 250,000

____Suburb near a large city

49. Approximately, how many patients do you treat per week? _____

50. How many years have you practiced medicine? _____

51. Did you receive your medical training in the United States?

Yes ____ No ____

52. What year did you complete medical school? _____

53. Age at last birthday? _____

54. Race (check appropriate box)

White _____

Black _____

Oriental _____

American Indian _____

Other (please specify) _____

55. What is your medical specialty? _____

48. In what size town or city do you work?

____ Rural (in open country, farmland, etc.) population under 2,500

____ Small city or town, population under 50,000

____ Medium city, population between 50,000 to 250,000

____ Large city, population over 250,000

____ Suburb near a large city

49. Approximately, how many students do you see per week? _____

50. How many years have you been a guidance counselor? _____

51. Were you employed as a teacher before you became a counselor?

Yes _____ How many years? _____ No _____

52. What is the highest degree you hold? _____

53. In what year did you receive that degree? _____

54. Age at last birthday? _____

55. Sex Male ____ Female ____

56. Race (check appropriate box)

White _____

Black _____

Oriental _____

American Indian _____

Other (please specify) _____

Police

48. In what size town or city do you work?

____Rural (in open country, farmland, etc.) population under 2,500

____Small city or town, population under 50,000

____Medium city, population between 50,000 to 250,000

____Large city, population over 250,000

____Suburb near a large city

49. Approximately, how many family calls do you answer per week? _____

50. How many years have you been a police officer? _____

51. What is your rank?_____

52. What was the last year of school you completed or highest degree you hold?

_____

53. Age at last birthday?_____

54. Sex Male_____ Female_____

55. Race (Check appropriate box)

White____

Black____

Oriental____

American Indian____

Other (please specify) _____

Thank you for taking the time in filling out this questionnaire. If, during the questionnaire you indicated that you had encountered a suspected case of child abuse and/or reported that case, we would like to interview you so that we might get a broader picture of how you dealt with that case. We anticipate conducting the interviews next summer and they will take about 1 hour of your time. As with the questionnaires, the interviews will be conducted so as to maintain your anonymity.

If you think you would like to be interviewed by one of our staff members, please fill out the enclosed card. We will get in touch with you in the late spring to try to set up an appointment with you.

Thank you.

Dear Professor Gelles,

Yes, I would be willing to talk with you about my experiences with cases of child abuse. I understand that you will contact me sometime in the late spring early summer.

Name _____

Adress _____

_____

_____

Phone where I can be reached from 9:00 a.m. to 5:00 p.m.

_____ or other times _____